

DEPARTMENT OF MENTAL HEALTH/MENTAL RETARDATION SERVICES

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Please fill in the following information:

Today's date \_\_\_\_\_

Name \_\_\_\_\_

Birthdate \_\_\_\_\_ Medical record # \_\_\_\_\_ Phone Number

(H) \_\_\_\_\_ (W) \_\_\_\_\_

Address \_\_\_\_\_

**I understand the Department may or may not add an addendum to my medical record based on my request, and under no circumstance, is able to alter the original documentation of the medical record. This request for an addendum may be made part of my permanent medical record and will be sent to individuals/organizations identified below as having relied on the content of my medical record.**

Describe the information you want amended (e.g., lab test results, physician notes) \_\_\_\_\_

Date(s) of information to be amended (e.g., date of office visit, treatment, or other health care service) \_\_\_\_\_

What is your reason for making this request? \_\_\_\_\_

What would you like to add/ change to the record? \_\_\_\_\_

Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, or other health care provider? yes no

If yes, please specify the name(s) and address(es) of the organization(s) or individual(s). \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**FOR HEALTH CARE ORGANIZATION USE ONLY**

Amendment has been: ☐ Accepted ☐ Denied

If denied, check the reason for denial: ☐ Health information was not created by this organization

☐ Health information is accurate and complete ☐ Health Information is not part of the individual's designated record set

☐ Originator of the record is not available because \_\_\_\_\_

☐ Federal law forbids making the health information in question available to the individual for inspection (e.g. psychotherapy notes)

Staff comments \_\_\_\_\_

**The Information Security Officer must review all Denials**  
to individual

☐ Denial letter sent

Signature of Staff Person \_\_\_\_\_

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